DELAWARE HEALTH AND SOCIAL SERVICES
Division of Substance Abuse and Mental Health
**1901 N. Dupont Highway, New Castle, DE 19720 Phone: (302) 255-2700**

**CERTIFICATE FOR INVOLUNTARY ADMISSION OF PATIENT TO DELAWARE PSYCHIATRIC CENTER AND/OR CERTIFIED TREATMENT FACILITY PURSUANT TO DELAWARE CODE CHAPTER 50, TITLE 16**

**Title 16, Section 5003, Delaware Code**

**5003, Provisional Hospitalization by Psychiatrist's Certification.**

**No person shall be involuntarily admitted to the hospital as a patient except pursuant to the written certification of a psychiatrist that based upon the psychiatrist's examination of such person, such person suffers from a disease or condition which required him to be observed and treated at a mental hospital for his own welfare and which either renders such person unable to make responsible decisions with respect to his hospitalization, or poses a present threat, based upon manifest indications, that such person is likely to commit or suffer serious harm to himself or others or to property, if not given immediate hospital care and treatment. The certificate shall state with particularity the behavior and symptoms upon which the psychiatrist's opinion is based, shall include (where available) the name and address of the spouse or other nearest relative or person of close relationship to the alleged mentally ill person, and shall state that such person is not willing to accept hospital care and treatment on a voluntary basis or that he is incapable of voluntarily consenting to such care and treatment.**

**PART 1. (To be completed by certifying psychiatrist)**

**The undersigned certifies that he is a physician licensed to practice medicine in the State of Delaware and specializing in the field of psychiatry and he has examined:**

_____
**Name of Patient**

_____
**Address of Patient**

**Age:_____ Date of Birth:_____ Religion:_____**

**Patient's spouse, other nearest relative, or person of close relationship:**

_____
**Name** **Relationship**

_____
**Address** **Telephone Number**

**As a result of my examination of the patient, I am of the opinion that the patient suffers from a disease or condition which requires him (or her) to be OBSERVED and TREATED at a MENTAL HOSPITAL for his (or her) own welfare.**

**The disease or condition:**

**_____ renders the patient unable to make responsible decisions with respect to his hospitalization**

**_____ poses a present threat, based upon manifest indication, that the patient is likely to commit or suffer serious harm:**

**_____ to himself (or herself) _____ to others _____ to property**

**The behavior and symptoms upon which my opinion is based are as related to me by others (state whom):**

**As observed during my examination of the patient:**

**And further:**

**_____ the patient is not willing to accept hospital care and treatment on a voluntary basis.**

**_____ the patient is incapable of voluntarily consenting to hospital care and treatment.**

**Name of family physician or psychiatrist_____**

**Physical conditions, which require immediate or continuous attention:**

**Signed:_____, M.D.**
**Physician Specializing in the Field of Psychiatry**

**_____, M.D.**
**Name Printed**

**Address:_____**

**Date:_____ Time:_____ AM. PM.**

**PART 2. (to be completed by hospital staff after provisional admission)**

**NOTIFICATION OF RIGHTS**

**I certify that I have this day delivered to, a copy of 16 Del. C., Sec. 5161, Rights of a Patients in Hospitals for the Mentally Ill, and other rights set forth in Title 16, Delaware Code.**

**Received:_____** **Name:_____**
**Patient's Signature**

**OR** **Title:_____**

**Patient refused to sign_____** **Date:_____**

**CERTIFICATION OF MENTAL ILLNESS AND NEED FOR TREATMENT (to be completed only when provisional admission was made on the certificate of a psychiatrist not employed by the Delaware Psychiatric Center)**

**I have examined the Psychiatrist's Certificate for Involuntary Admission of Patient to Delaware Psychiatric Center in the case of :**

_____
**Name of Patient**

**And have personally conducted a psychiatric examination of the patient; the behaviors and symptoms observed during my examination of the patient are as follows:**

_____
_____
_____
_____
_____
_____
_____
_____
_____

**In my opinion, the patient:**

**IS / IS NOT a mentally ill person requiring hospital confinement.**
**(Circle One)**

**DOES / DOES NOT require treatment pending judicial proceedings under provisions of 16 Del. C. Ch 50.**
**(Circle One)**

**IS / IS NOT capable of waiving procedural right including retention of counsel, retention of psychiatrist**
**(Circle One) or other qualified medical expert to testify in his behalf, and the hearing in court.**

_____ _____
**Signature of Examining Psychiatrist** **Date**

**CERTIFICATION OF FINANCIAL ABILITY TO RETAIN PRIVATE MEDICAL, PSYCHIATRIC AND / OR LEGAL REPRESENTATION:**

**Based upon financial information obtained from**

_____

**Name of Informant** **Relationship**

**I am of the opinion that** _____

**Patient's Name**

**_____ Can afford to retain legal counsel.**

**_____ Cannot afford to retain legal counsel.**

**_____ Can afford to retain a psychiatrist or other qualified medical expert.**

**_____ Cannot afford to retain a psychiatrist or other qualified medical expert**

_____ _____

**Name of Guarantor (If private legal, medical or Psychiatric representation is to be retained)**

**Street**

_____

**City** **State** **Zip Code**

_____

**Telephone Number**

**Being unable to afford private representation, the patient respectfully prays the court to appoint and assume financial responsibility for the services of**

**_____ Legal Counsel** **_____ Psychiatrist or other qualified medical expert**

_____

**Financial Resources Examiner**

_____

**Date**

**APPROVED:**

_____

**Hospital Official**

_____

**Date**